The Dutch Participatory State : Shift from a Welfare System of Collective Solidarity Towards Individual Responsibility in a Participatory Society

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1. Introduction

Although the elements of workers insurance and citizenship-based systems coexisting in the Dutch welfare system have led some commentators to refer to the Dutch systems as a hybrid model and not easily applicable to a one ideal/typical model (Esping-Andersen, 1996), these elements have constituted a strong base for collective solidarity in this small state. This collective solidarity - the once 'beating heart' of the Dutch social insurance system (van der Aa et al., 2017) is currently suggested to be suffering from symptoms of rhythmic disorders. The fundament of the collective solidarity was laid already at end of the nineteenth century, when the first contributory social instance schemes for the waged workers were introduced. After the Second world war the Dutch system was rapidly expanded along the lines set out by the Van Rhijn commission (1945). The Van Rhijn commission was deeply inspired by the Beveridge model in Britain and it highlighted the idea of society, together with the state, being liable for organizing national social protection (Van Rhijn 1945: 4). The individual responsibility was at the centre of the new model: the commission urged citizens to do all reasonably expected to acquire security and protection (Van Rhijn 1945: 4). In the course of the 1950s and 1960s, a welfare system with high levels of horizontal as well as vertical solidarity was formed. The vertical solidarity meant that 'good' risks paid for 'bad risks' and horizontal solidarity meant that higher incomes paid for the lower incomes in the collective arrangements (van Oorschot 2009). In the 1960s, and early 1970s, expansion was set forward, as Minister Veldkamp of Social Affairs famously declared that every citizen to have a right to self-realization and to equality of change (TK 1962/63) (van Oorschot, 2009: 364). The golden age of welfare state period in the Netherlands came to an end with two oil crises of the 1970s. During this period, also known as the incubation period of the 'sick man' of the Netherlands, a more dominant tone of austerity and stronger citizens responsibility was set out (Starke, Kaasch, & van Hooren, 2013). The overarching trend of retrenchment in the 1980s,

was followed by a dominant shift towards politics of work in the 1990s (van Gerven, 2008). As an update to the previous Handbook (van Oorschot, 2009 in Schubert et al., 2009), this chapter describes the Dutch welfare system in 2018 and unravels three reform sequences of the Dutch welfare system in the last decades eading towards a participatory state (as discussed in Section 3). To analyze the changes in the regulations, ideas and types of welfare state change a following research question is guiding this exploration: *How has the Dutch welfare system changed between 1994 and 2018?*

The findings of this chapter propose that, on ideational level, the changes in last 20+ years indicate a development that Hall (1993) calls as a paradigmatic change. The fundaments of welfare states have undergone a normative reorientation from a solidaristic and state-provided collective welfare state provision of the 1950s and 1960s to a participatory state in 2010s, where citizens actively engage in the labor market and in the co-creation of social service delivery. It is a story of reinventing the society, similar to what Van Rhijn plan did decades earlier. But participation society is not a return to the past, rather it is a reinvention of the social contract, it puts power back to the people and lifts the state out of the welfare (as much as possible). The participation society is manifestation of the hegemony of activation and participation norms that subsumes both the citizens as well as local municipalities. It is an outcome of a series of reforms vis-a-vis creation of a new dominant layer of state regulation (Streeck and Thelen, 2005) that materialize the urgency of decentralization, introduce risk differentiation, and urge for stronger citizens participation. In the context of constant austerity and retrieving state and public sector, paradigmatic changes of decentralization together with de-institutionalization and re-familiazation of care have altered fundamentally the welfare rights to be cared and welfare obligations to care. This chapter also portrays a welfare landscape, where we see paradigmatic changes in some areas and almost none in other areas.

2. General structures of the Dutch welfare system

In this section, the general structures of the Dutch welfare system is described. A more detailed overview of these general characteristics is found in the first edition of this Handbook (van Oorschot, 1998 in Schubert et al., 2009).

2.1. Priorities

As Table 1 indicates the Dutch social protection spending constitutes a significant share of the public spending. In 2017, the total social spending amounted 30.2% of the percentage of the Gross Domestic Product (GDP) and the trend has been towards growing social protection spending. In comparison to EU-28 spending (28.6 % in 2014), the Dutch social protection spending is above average.

Table 1: Social protection expenditure, the Netherlands, 1995-2015

	nl			eu28			eu15		
year	*total (mio €)*	*% GDP*	*PPS per inhab.*	*Total (mio €)*	*% GDP*	*PPS per inhab.*	*Total (mio €)*	*% GDP*	*PPS per inhab.*
1995	98,419.20 (b)	24.8(b)	5,761.08	:	:	:	1,869,415.56	26,5	4,688.71
1996	97,453.20	27.8	5,891.55	:	:	:	1,971,768.55	26,6	4,924.63
1997	97,498.08	26.8	6,126.53	:	:	:	2,048,453.88	26,2	5,112.87
1998	99,933.49	25.9	6,289.95	:	:	:	2,110,012.32	25,8	5,262.37
1999	103,909.00	25.0	6,525.75	:	:	:	2,214,943.56	25,8	5,500.34
2000	109,447.00	24.4	7,029.24	:	:	:	2,347,326.14(p)	25,5	5,837.71(p)
2001	115,835.00	24.3	7,191.02	:	:	:	2,449,980.98(p)	25,7	6,080.56(p)
2002	125,712.00	25.4	7,734.81	:	:	:	2,562,471.09(p)	26	6,319.12(p)
2003	133,143.00	26.3	7,715.85	:	:	:	2,657,662.71(p)	26,5	6,493.72(p)
2004	137,242.00	26.2	8,055.84	:	:	:	2,771,854.86(p)	26,4	6,725.22(p)
2005	140,577.00	25.8	8,370.53	:	:	:	2,889,500.99(p)	26,6	7,013.25(p)
2006	153,700.00	26.5	9,191.54	:	:	:	3,007,885.73(p)	26,2	7,270.41(p)
2007	160,133.00	26.1	9,633.22	:	:	:	3,118,525.82(p)	25,9	7,487.35(p)
2008	169,018.00	26.4	9,859.75	3,387,028.75(p)	25.9(p)	6,757.67(p)	3,195,211.33(p)	26,6	7,658.60(p)
2009	181,250.00	29.4	10,107.91	3,533,143.94(p)	28.7(p)	7,028.04(p)	3,344,902.25(p)	29,4	7,928.97(p)
2010	187,514.00	29.7	10,048.40	3,667,547.18(p)	28.6(p)	7,279.52(p)	3,467,209.30(p)	29,4	8,171.41(p)
2011	194,203.00	30.2	10,321.20	3,735,088.49(p)	28.3(p)	7,417.84(p)	3,533,100.02(p)	29,1	8,310.18(p)
2012	199,724.00	31.0	10,709.57	3,859,799.72(p)	28.7(p)	7,649.10(p)	3,656,348.31(p)	29,5	8,537.54(p)
2013	203,593.00	31.2	10,829.05	3,913,655.87(p)	28.8(p)	7,733.21(p)	3,705,912.85(p)	29,7	8,619.55(p)

2014	205,176.00	30.9	10,872.89	4,016,755.91(p)	28.6(p)	7,912.48(p)	3,806,673.98(p)	29,5	8,796.65(p)
2015	206,177.00	30.2	11,116.96	:	:	:	4,000,226.25	29.3	9,179.54

Source: Eurostat 2018; accessed the 10th of October 2018; (p): provisional value; (b): break in time series

A large share of the social spending is targeted to traditional social protection areas, such as old age and health related schemes. Table 2 below portrays a rise of spending stemming from ageing of population. Compared to projections in old-age dependency rates among the EU countries, the Netherlands does reasonably well (see also van Gerven, 2016), but given the high per capita spending to old age and health, the ageing will strain public budgets more than it does in many other EU countries.[1]

Table 2: Social Protection Benefits by Function, 1995-2015 (% of total expenditure)

	1995	2000	2005	2010	2015
Total expenditure	100	100	100	100	100
Social protection benefits	93.91	93.69	93.17	93.36	94.14
Family/children	4.4	4.55	4.72	3.92	3.62
Unemployment	8.89	6.17	6.2	4.42	4.91
Housing	1.27	1.41	1.22	1.2	1.51
Social exclusion n.e.c.	2.7	2.83	2.14	4.27	4.14
Sickness / healthcare and disability	39.09	38.36	38.84	41.66	40.02
Old age and survivors	37.57	40.36	40.06	37.89	39.94

Source: Eurostat 2018, accessed the 11th of October 2018

Unlike many other European welfare systems struggling with high unemployment rates, the Dutch system is challenged with the high numbers of disability benefit beneficiaries. As the only EU country, the

[1] In 2060, the projected number of persons aged 65 and over (expressed as percentage of the projected number of persons aged between 15 and 64) is expected to be lower in the Netherlands (47.47) than the average number of persons aged 65 and over across all 27 EU member states (52.55) (European Commission, 2011: 146 in Van Gerven 2016).

Netherlands has a generic disability scheme that does not differentiate work injury from not-work-related injuries. At the begin of the 1980s, the high disability receipt ('the Dutch disease') became an epidemic that politics wanted to cure (for an extensive overview of the disability benefit reforms in between 1980 and 2006 see van Gerven, 2008). The number of recipients on *Invalidity Insurance Act* (Wet arbeidongeschiktheid, WAO) increased six-fold from 1980 to 1995: from 65,000 people to 410,00 (Van Gerven, 2006: 125). To cut the numbers, a series of reforms were introduced in the 1990s and 2000s. There reforms fostered activation as well as tightened the conditions both for accessing and remaining on the disability scheme (van Gerven, 2008; Kurzer, 2013). Curing the Dutch disease meant that WAO recipients as well as employers and employers' organizations, trade union and implementing bodies all were objected to reforms of new financial incentives and new responsibilities for job retention. The new scheme *Employment Capacity Act* (Wet werk en inkomen, WIA, in effect from 1 January 2006, strongly promoted a return to work together with stringent gatekeeper laws (*Gatekeeper law and the Law on wage payment by the employer during first two years in 2004*) governing the first two years of sickness. As Table 2 above illustrates, spending on long-term sickness benefits decreased in 2000s but the expenditures are recently growing again. Due to ageing population future projections foresee further growth: the old age dependency ratio (per 100 persons) is projected to increase from 28.4 in 2018 (Eurostat, 2018) to 40.0 in 2030 and 45.6 in 2050 (European Commission, 2011: 146).

2.2. Funding and administrative structures

The Netherlands is a unitary state with a constitutionally created legislature of 12 provinces, and with 380 municipalities (in 2018). Each tier of government (central, provincial and local) has its own range of action as well as tasks related to the implementation of state legislation and policy. In the decentralized state like the Netherlands, municipalities possess a large degree of autonomy from the central government. The financial system is largely decentralized, local governments are financed based on defined formulas. Since 2000s several social domains have been decentralized from the state to the local level. In 2004, the *Work and Social Assistance Act* (Wet werk en bijstand, WWB) replaced the former social assistance act and gave birth to a new (workfarist) policy objective prioritizing work above other income (for social assistance, see also section 3.6). The act activated the citizens, but the decentralization created strong incentives for local governments (TK 28870, No. 3. 2002-2003: 2 in Bannink & Ossewaarde, 2012: 607). The 2007 *Social Support Act* (Wet maatschappelijk ondersteuning, WMO) intensified the citizen participation and obliged local governments to include civil associations and active citizens more actively in the policy process (see

also Bannink & Ossewaarde, 2012). These laws, together with political narrative surrounding the participatory state, paved a way for a fundamental decentralization of social policy from 2015. Framed as part of the sustainability discussion, the Rutte II government announced in 2013 the decentralization of youth care, long-term care and income support (Regeerakkoord, 2012). For youth care (*Youth Services Act)*, employment and participation (*Participation Act*), and care for the long-term ill and the elderly (*WMO*) most of the tasks were delegated to the level of municipalities under the policy agenda 'one family, one plan, one coordinator' with one budget and one government coordinator (Regeerakkoord, 2012). The earmarked grants replaced the general grants to municipalities and provided more spending autonomy but also stronger incentives to curtail local public spending. The societal and political effects of the decentralization are to unfold in the future, yet already municipalities have expressed both potential efficiency improvements but also concerns with regard to risks and regional inequalities.

The Dutch are known to be result-seeking and consensus-seeking. The high degree of corporatism and the 'Dutch polder model' characterize the institutionalize interactivity between various stakeholders. Since WW II, the Dutch industrial relations signify the inclusion of the tripartite Social and Economic Council (Sociaal Economische Raad, SER) and the bipartite Foundation of Labour (Stichting van de Arbeid, STAR). This institutionalized process of socio-economic policy making led in the past to reasonably flexible adjustment of the welfare system (such as the Agreement of Wassenaar in 1982 that led to the so-called Dutch job miracle in the 1990s). Yet in the current era the Dutch industrial relations are signified by increasing unilateralism where government does not incline to negotiate with trade unions. The once so vivid Dutch corporatism is facing heavy winds both from their negation partners (employers' organization and government) as well as from the field (resulting from the diminishing trade union membership) (see also Keune, 2016).

Fiscal welfare remains to play a reasonably small role in social protection in the Netherlands, with exemption for tax provisions for working people (with underaged children). Welfare society institutions, like churches, charities, social movements play a marginal role in the formal system. The grassroot level, such as third sector and volunteers are, however, a considerable pool of resources in organizing social services, such as organizing day activities for the elderly and sport clubs.

2.3. Performance

High labor market participation has been a key to the economic performance in the Netherlands. In the 1990s the rapid labor market participation constituted the so-called Dutch Miracle (see e.g. Trommel & van der Veen, 1998; van Gerven, 2016; Visser & Hemerijck, 1997). As Table 3 indicates above, the employment growth has been strong for women (Visser, 2002).

Table 3: Outcome indicators the Netherlands 1995-2017

	1995	2000	2005	2010	2015	2017
Employment rates (15-64)	67	74.3	75.1	76.8	76.4	78
Female employment rate	55.2	64.1	67.6	70.8	70.8	72.8
Part-time employment rate (total)	34.6	38.2	42.7	45.2	46.6	46.6
Part-time employment rate (female)	66.2	59.4	73.6	74.7	75.3	74.1
Temporary contracts	11.6	12.9	12.7	14.9	15.6	16.7
Gender pay gap					17.8	16.1
Unemployment rate (15-64)	8.3	3.7	5.9	5	6.9	4.9
Youth unemployment rate (15-24)	16.8	8.2	11.8	11.1	11.3	8.9
Elderly unemployment rate (55-64)	3.5	1.9	4.1	4.0	8.1	5.5
Gini-coefficient of equivalised disposable household income	29	29	26.9	25.5	26.7	26.9
At-Risk-of-poverty or social exclusion			16.7	15.1	16.4	12.7
At-risk-of-poverty after social transfers	11	11	10.7	10.3	11.6	6
In Households with no or very low work intensity			8.4	10.2		
Severely deprived				2.2	2.6	2.6

Source: Eurostat 2018c, accessed the 27th of June, 2018.

This trend of growth of female labor market participation goes vis-à-vis with government's key position from the mid-1990s that work should be the (main) pathway to welfare and social inclusion. Regarding the employment rate of 78 per cent for the age group 20 to 64 in 2017, the Netherlands excels in comparison

to EU28 average (of 72.2 per cent) (Eurostat 2018). However, 46 per cent of the total employment in 2017 is part-time employment. This double as high in compared to the EU28 average (18% in 2017). Most of these part-time workers are women (74% in 2017 in comparison to 31 per cent of female part-time workers in EU28 in the same period (Eurostat 2018). With the unemployment rate of 4.9% (as percentage of active population) in 2017, The Netherlands' has relatively low unemployment rate in comparison to EU28 average (7,6 %) or to Euro area (18 countries 9.1%) (Eurostat 2018). During the great recession, the unemployment rose in the Netherlands' from 4.4 per cent in 2009 to its highest point of 7.4 per cent in 2014. A large proportion of labour market shocks was cushioned by the temporary agency workers who withdrew from the labor market and by the temporary policy measures (training and part-time unemployment insurance, see section 3.4). The crisis affected the Netherlands reasonably little and the country recovered reasonably soon (for more about the effects of economic crisis in the Netherlands, see van Gerven, 2016). The unemployment levels have descended to those prior to the recession (4.9 in 2017). Like other European countries, the highest unemployment rates can be found among the youth. In the Netherlands', the youth unemployment rose from 8.6 per cent in 2009 to its highest peak of 13.2 in 2013 and was later settled to 8.9 per cent in 2017. This is considerably lower than the Euro-area peak of 24.4 per cent in 2013 and the latest youth unemployment rate of the Euro area average of 18.8 per cent in 2017 (Eurostat 2018). The poverty and poverty levels have been reasonably stable in the Netherlands, although there is an increase in the numbers for the people at risk of poverty in the recent years.

3. Policy sectors

The Dutch system contains four types of schemes. First, the national insurances for old age (state pension), survivor pensions and child benefit. These are compulsory contributory schemes covering all citizens, paying flat-rate benefit (with a means test for survivor's pension) they are administered by the semi-public Social Insurance Bank (Sociale Verzekringsbank) under the control of the Ministry of Social Affairs. Health care insurance (zorgverzekeringswet, ZVW) is a compulsory contributory scheme. It's a universal system, regulated by the government and provided by private insurers.

Second, the workers insurances cover the unemployment and disability schemes and occupational pension schemes. There are compulsory and contributory schemes administered by the Administrative Public Body for workers insurances (Uitvoeringsorgaan Werknemersverzekeringen, UWV) contributions paid are related to wages, and benefits paid are partly wage related, partly age related. Third, the public safety net, social assistance is non-contributory, tax funded, means-tested assistance provided by the local

governments. Fourth, the privatized scheme, like sickness benefit has shifted the responsibility from the public to private sector. The sickness benefit was privatized in 1997 and made the period of first two years of wage payment obligatory for the employers.

Below, we provide the description and analysis of the three reform sequences between 1994 and 2018 with respect to the main policy sectors. The changes are summarized in Table 4.

Table 4: summary of the reform sequences

Time frame	**Policy sector**	**Three-dimensional approach for analysing welfare system change**				
		Regulations		**Ideas**	**Types of change**	
		Step 1	**Step 2**		**Step 1 process**	**Step 2 output**
1994-2006	Unemployment	Tightening benefit rights, ALMP	Retrenchment, restructuring with a new layer	Neoliberalism (activation/work above benefits)	Incremental	Continuity from 1980s
	Social assistance	Activation & sanctions & decentralization	Retrenchment, restructuring	Neoliberalism (activation/workfare)	Incremental	Continuity from 1980s
	Labour market	Flexwork, part-time	Restructuring	Flexibilization	Incremental	Continuity from 1980s
	Sickness & disability	Tightening benefit rights, activation,	Retrenchment, restrcuturing	neoliberalisation	incremental	Continuity from 1980s

		rprivatsation sick pay				
	Long-term care	Institutionalization of long-term care	Expanding	Defamiliarization (as a norm)	Incremental	Continuity from 1968
	Family policy	Institutionalization of child care	Expanding	Defamiliazation (with a choice) 'social' investment	Abrupt in establishment	Discontinuity
2006-2010	Health care	Reform of basic insurance (benefit, provision, administration)	Restructuring	Neoliberalism (marketisation, decentralization)	Abrupt in establishment of market system logic in 2006	Thereafter continuity
	Social assistance	participation law	Restructuring	Participation, decentralization, self-responsibility	Abrupt in establishment (but builds on previous activation)	Continuity/discontinuity
	Family policy	Cuts in child care	Retrenchment	Neoliberalism, re-familiazation	Incremental	Reversal
2011-	Old-age pension	Retirement age	Retrenchment	Neoliberal (sustainability)	Incremental	continuity
	Unemployment and		Retrenchment and	Neoliberal (flexibility)	Incremental	continuity

	labour market		flexibilization			
	Long term care		Restructuring	Decentralization, refamiliarization	abrupt	discontinuity

3.1. Old age policy/pensions

The national old age pension scheme, introduced in 1957, was modernized in the 1980s by individualizing benefits for both partners (van Oorschot 2009: 368). Although the integrated Dutch public and private mandatory provision of retirement income has been considered a reasonably bullet proof for the demographic change, a series of structural reforms were called upon before and at midst of the economic crisis of the late 2000. In the context of uncertainty of the pension funds - due to the credit crisis, historically low interest rates and investment losses during the economic crisis- growing urgency has been rising around a fundamental pension reform including the first pillar basic state pensions and second pillar occupational pensions. The Rutte I government (2010-2012) framed its initial reform plans as to assure the sustainability of the pension system in the long-run. Both Rutte I and II (2012-2017) governments has pushed towards increasing the statutory retirement age, first from 65 to 66, and in steps to 67 years. These plans met fierce opposition by the social partners, especially after the Rutte II announced its speeding up of the time planning and linking the retirement to the life expectancy. In June 2015, a law was however adopted to accelerate the pace of the lifting the retirement age from 2016. The retirement was set to 66 years from 2018 and 67 years in 2021. Starting from 2022 the retirement age is periodically adjusted to the increase of the average life expectancy.

After longest cabinet negotiations ever in the Dutch modern history (208 days), the Rutte III (2017-) cabinet with Liberals (VVD), Christian democrats (CDA), democrats (D66) and Christian party (CU) introduced its plans in 2017 to set forward its quest to modernize the pension system (coalition agreement 2017). The cabinet (Coalition agreement, 2017) indicates interest in following the Social and Economic Council's (SER) earlier advices from 2015 and 2016 to combine the collective risk sharing of the current system with new personal pension capital. Together with social partners (trade unions and employer's

organization), the government is working out the plans in 2018 but given the difficult relationship of the government with the trade unions, no quick fixes are to be expected.

3.2. Health care

Next to pension spending, health care spending is the highest in the overall public spending. The health insurance is a universal system and comprises of two statutory forms of insurance: health care insurance covering the medical care and the long-term care (see section 3.4). As discussed in section 2.1, disability insurance scheme is an important social protection scheme in the Netherlands. The current system of medical health care insurance is based on *Dutch Healthcare Act* of 2006 (Zorgverzekeringswet, ZVW) comprising of a compulsory basic health insurance for primary health care. It replaced the previous two-tier system of old sickness fund scheme and voluntary private health insurance scheme. The ZVW introduced competitive incentives for insurers and insured. Under the current scheme, all Dutch residents are insured, and the Dutch government annually defines the costs and content of the basic insurance packet with a defined set of treatments. In addition to the compulsory basic package, people can opt out for a more extensive insurance coverage and services. Being universal insurance, private health insurance companies are obliged to accept every citizen for the basic health insurance. Premiums may not be related to health status or age, rather risk variances are compensated through risk equalization and a common risk pool.

Although praised of its solidarity, universal access and good quality, the health care is straining public finances, as discussed in section 2. In comparison to Euro-area (19 countries) the Netherlands spend more per inhabitant; in 2014, this was 874 per inhabitant in comparison to Euro-area average 612 per inhabitant (Eurostat, 2018). The costs were also behind the 2006 Reform. Introduction of market competition in health care already had already been proposed by the Dekker Commission in 1987, but after a series of smaller changes in end of 1980s and in 1990s, the Balkenende II cabinet (2003-2006) announced in 2003 the introduction of a new compulsory basic health insurance. Within the system of managed health care competition, insurance companies are obliged in 2006 ZWV to compete on the market for (new) clients as well as on the market of health care suppliers. The role of government changed from direct control to merely setting up the rules of game and overseeing the markets. Each year insurers are required by the government to negotiate with providers for lower prices for services or medicines.

Regardless of the hopes raised at the introduction of the ZVW, the competition has not lowered the health care spending (see Table 2). Surmounting costs, especially the high administrative costs, have given

a reason for scholars relate to similarities between the Dutch system and the US system (Delsen 2016: 16). The Rutte II (2012-2017) and III (2017-) governments called upon various reforms: reduction of variation in medical practice and preventing unnecessary medical treatment, stricter package management and greater cooperation between providers (Regeerakkoord, 2012; 2017). The reforms implemented have, however, foreseen that clients bare more cost of their health care: the limitation of package coverage has led a growing importance of the supplementary health insurance; leading to rising inequality among the population. Furthermore, the annual compulsory excess has been raised (almost) annually: from €255 in 2006 to €385 in 2018.

3.3. Labour market and unemployment

From the mid-1990s, the Kok I (1994-1998) and II (1998-2002) governments have steered the 'welfare without work' system toward a new participatory system that priorities 'work above welfare' (Van Gerven, 2015). First phase started already in 1980s and comprised of series of reforms to social security cutting the unemployment insurance (WW) benefit rights and limiting access to it (for an extensive overview of the reforms 1980 and 2006, see van Gerven, 2008). The system revision of 1986 and further reform in 1994 linked the unemployment protection program closer to employment. In the 1990s, policy goals shifted to re-integration of the beneficiaries. The reforms in unemployment insurance aimed at making the WW a bridge 'between two jobs', rather than a 'life raft' of 'hammock' for the unemployed (van Gerven, 2008). Following the activation developments at the EU level (Stiller and van Gerven, 2012) more activation was introduced and these active labour market policies (ALMP) went together with stricter sticks for benefit recipients. These reforms strengthened the governments' position that work should be the pathway to welfare and social inclusion.

Before the economic crisis, the last Balkenende (IV) cabinet (2007-2010)– portrayed by Koolmees (2013) of being 'reform tired'- did not propose drastic reforms. The crisis management meant increasing funding for training, retraining and the prevention of youth unemployment and the temporary part-time unemployment benefit (Deeltijd WW) for companies struggling amid of the crisis (see van Gerven, 2016 for a more detailed analysis of the crisis measures).

The three consecutive governments in the 2010s, governed by Prime Minister Rutte, I (2010), II (2012-2017) and II (2017-) introduced various measures in the field of social protection and labor market policies. Some of these measures were introduced as path-breaking, such as introduction of higher pension

age discussed in 3.1. section and a partial privatization of the unemployment insurance shifting the responsibility of unemployment benefit payments to the former employers for the first six months (see i.e. TK, 2012/2013); following the logic of the sickness benefit privatization in the mid-1990s. However, most reforms to unemployment insurance implemented since 2010 have not fundamentally changed the social security landscape in the Netherlands. Similar to the 'price' and 'volume' policies of the 1980s and 1990s (van Oorschot 2009), cuts have made it less attractive to stay outside of the labor market.

There have been, however, structural changes in the employment protection legislation (EPL) throughout the 1990s, 2000s and 2010s. Many of these reforms were related to the flexibilization of employment. Although part-time employment in the Netherlands is crucial aspect of the Dutch welfare system: providing favorable labor conditions for high employment and making reconciliation of work and family easier (also section 3.5), it is important to note that part-time work (as a kind of labor market flexibilization) never went with a decline of the employment protection of workers. At least in legal terms and on paper. Laws under the Kok I and II cabinets such as the '*Flexicurity agreement'* of 1995 and *Working Hours Act* of 2000 were both developed under close collaboration with the social partners. These laws improved the rights of the workers in the secondary labor market: for instance they enshrined the equal rights for part-time workers and apply to all areas of social partners, including wages, social security, training and education etc. (Houwing, 2010). Regardless the amicable industrial relation in the past and their potential to advance welfare state reform in the Netherlands, the EPL has remained a thorny issue on the political agenda in the 21st century. In the last decades, changes are frequently being demanded by the employer's organizations and fiercely opposed by the trade unions. The relationship between trade unions and government has been troublesome in the 2010s (see e.g. Keune, 2016), but few social pacts between the government and the social partners have been agreed upon.

Social accord in spring 2013 led to the enactment of *Act on Work and Security* (Wet Werk en Zekerheid, WWZ) in 2014 introducing major changes in employment and dismissal law. The main aim of the bill was to create a more equal balance between insiders: employees with permanent contracts and high levels of protection (full-time or part-time) and outsiders: flexible workers with temporary or precarious contract (such as zero-hour contracts) providing little or no protection. On the background of the reform was the concern of the increase of the flexible contracts from 17 per cent in 2000 to 27 per cent in 2013 of the overall job market, and of few workers moving from temporary to permanent contracts (Gruenell, 2013; see also Table 2 for the growth of temporary contracts in the Netherlands). Although the law reduced the maximum duration of a series of fixed-term contracts from 36 to 24 months, disagreements prevail whether the aim to stop the endless extension of short-term and temporary contracts by employer is reached. The WWZ Act also simplified the dismissal procedure for the employer and employee. The Rutte II government

had introduced fundamental reforms to unemployment insurance benefits in its coalition agreement, but these watered down in negotiations of the social agreement of 2013. In the WWZ Act, the maximum period of entitlement for unemployment benefits was reduced from 38 months to 24 months but the (partial) privatization was no longer part of the discussions.

With eye on future labor shortages due to demographic change, the Rutte III (2017-) government is currently searching for opportunities to increase the number of hours each person works. Compared with many other European countries, the Netherlands has a large proportion of its workforce on part-time contracts as discussed above. This at least theoretically suggests a potential pool of workforce once the baby boom generation has retired. This pool is however predominantly women: most part-time workers are female who choose to work part-time, often after becoming mothers, but sometimes already prior to motherhood. Several studies have shown, however, that even after the children grow out of the need of active care, women tend not to increase their working hours (Knijn and van Oorschot, 2008) and this labor force pool may not be so easily utilized. Also due to the fact that more responsibilities for caring of elderly (Van Den Broek et al., 2017) are currently devoted to this segment as discussed next.

3.4. *Long-term care*

The long-term care rector has witnessed considerable reforms in the last decades. The foundation of the Dutch long-term care system was created with *Exceptional Medical Expenses Act*, ABWZ, enacted in 1968 and providing a statutory scheme of public long-term care insurance. Initially the ABZW schemes focused on residential care (nursing and disability care), but over time, it came to include different types of care, such home health and social care, domestic care (home help), and psychiatric care. In the 1980 and 1990s the policy focus of the government was towards professionalization of nursing homes funded by ABWZ. Alongside the expansion of residential care (ensuring the supply-driven expansion), another trend was growing, namely the demand-driven expansion. In 1995, a personal budget was introduced to meet the various individual needs of people. The budget offered the beneficiaries a choice between care in kind, or cash payments that could also be used to purchasing services from private and market sector. Yet, the costs quickly expanded and the social security contributions for the AWBZ rose from 9.6% of gross wages in 1998 to 13% in 2004 (van Hooren & Becker, 2012). The first reaction to surmounting long-term care costs by the Balkenende's Christian democratic-led government in the 2000s was to cut costs and decentralize: increase co-payments for services; tightening eligibility criteria and shift home help services from the

ABWZ to local governments' social assistance programs. Yet, failing to address the problem of costs, another strategy was chosen that prioritizes informal care above formal care. Following the statement in the coalition agreement of 2003 that 'state responsibility ends at the front door' (Regeerakkoord, 2003), public policy now is that public care will intervene only when care at home - through the social network- is no longer manageable. This was also heart of the new *Social Support Act* (Wet Maatschappelijk Ondersteuning, WMO). The WMO, introduced in 2007, decentralized the home help services to local governments and increased marketisation of and competition in the sector. Unlike AWBZ, WMO is no insurance scheme under national government, rather a tax-based fund administered by the municipalities. Under the WMO, professional care is only provided when demand for care reaches beyond the possibilities of the person's own network. Municipalities have now great discretionary room for executing their responsibilities under WMO, yet the policy direction leans more strongly on the abilities of the informal caregivers (partners, children, broader family and social network) of an elderly person in providing (informal) care.

This is also at the very heart of the current system integrating the former AWBZ into three existing laws and adopting one new law in 2015 (Maarse and Jeurissen, 2016). First, residential care was adopted to new L*ong-term care act* (Wet langdurige zorg, WLZ). Second, insurance companies were made responsible for home nursing under the *Health Insurance Act* (Zorgverzekeringswet ZVW). Third, social care was transferred and decentralized to the municipalities under the *Social Support Act (*WMO), and fourth, preventive and mental health care for youth was transferred to *Youth Act* (Jeugdwet). The reform aims at cost containment and promote de-institutionalization as well as re-familiazation of long-term care. Following stricter criteria for institutional care, only people without any social network and no capacities to cope receive institutional care. This is reform fundamentally reformed the provision of the care. In the 2015 long-term care reform, new actors such as municipalities and health insurers will play a much larger role in organizing all types of care. Critical voices argue that many of these actors lack previous experience and expertise in this (Van Ginneken et al., 2015) and also the regional differences are likely to become more visible. The research looking developments between 2002 and 2014 already shows that more care and occasional household support is now delivered by the adult children -predominantly by daughters (Van Den Broek et al., 2017) and this trend will only be strengthened by the 2015 Act.

3.5. Family policy

The Dutch family policy strongly rests on the flexible labor market. The 'secondary' labor market has been the solution for the new social risks and enables the reconciliation of work and family responsibilities for women. The part-time has also allowed the government to maintain semi-formalized child care services and silence the discussions of a social investment state including extensive early childhood education schemes (van Gerven & Nygård, 2017). As Van Hooren and Beckers (2012: 99) noted, a fundamental change of child care provision occurred rather late, especially given the fact that elder care had underwent a serious formalization and institutionalization much earlier. Although initiated by the Labour party (PvdA) already in the late 1990s (Regeerakkoord, 1998) the *Work and Care Act* (WAZO) of 2001 passed only after the Christian democrats-Liberal coalition led by Balkenende I. The law radically changed child care provision by providing the child care payments to parents for various form of childcare. Parents were able to choose between a guest parent or a private or non-profit organization as day-care facility. At the same a generous tax deduction was introduced for parents and employers to make use of childcare. Consequently the number of children using care facilities increased rapidly what quickly made childcare becoming very costly for the state.

From 2007 the reform sequence changed to retrenchment: from 2007 employers were made responsible for bearing parts of the costs of child care of their employees and from 2009 several retrenchment reforms were adopted: parents' contributions were considerably raised, rights to subsidies were restricted and only registered guest parents with proper qualifications (rather than grandparents) became eligible for the subsidy. The policies have led to working parents bearing more financial responsibility for their children as well as using informal network for finding (cheaper) solutions for child care. They also strengthened the traditional coping strategies for reconciling work and family responsibilities: part-time work. Although both men and women work more part-time (as was seen in Table 3), and the child care remains the self-proclaimed task for mothers (and grandmothers) in the Netherlands. This partly explained by the institutional limitations of the Dutch family policy: the statutory paid maternity leave (zwangerschapverlof) of 16 weeks is very short in European standards, and the paternity leave (kraamverlof) was only extended from 2 days to 3 in 2017. The number of children in fulltime formal care remain very low in the Netherlands, In 2016, the percentage of children under the age of 3 in full time (30 hours or more) formal care was 5.4 per cent the Netherlands in comparison to 22.5 per cent in the euro area (19 countries) and much lower to the 21,4 percent for the neighboring country Germany and 28,5 per cent for Belgium. Also the percentage for children above three years of age (until the primary school) in full-time (30 hours or more) formal day care remains much lower (19.5 %) in the Netherlands in comparison to the Euro-area average (56.2 per cent for 19 countries) (Eurostat, 2018). In this age group (three plus), many children only go to childcare centres for a few hours a week. Eurostat (2018) figures shows that in 2016,

the average number of weekly hours of formal care for children under 3 years was 16 hours in the Netherlands, in comparison to 29 hours in Belgium and 28 hours in Germany for the same age group. Also, Eurostat shows that 74 per cent of children aged 3 or older (over the population of this age group) attend formal child care, for 1-29 hours a week.

The political attempts of the early 2000s to institutionalize the formal child care services and raise the number of working hours of the mothers were not successful. After the crisis period, and especially after the Rutte II and III cabinet again raising the subsidies for day care, the number of children from 3 years of age to minimum compulsory school making use of day care facilities has grown (from 13.2 % in 2015 to 19.5 % in 2016 for children in full-time (30 hours or more) day care, and from 71 % in 2013 to 74 % in 2016 part-time day care (from 1-29 hours) (Eurostat, 2018). Flexible working opportunities for women (working part-time and often only during the school-hours) and a tax system that supports the one and a half breadwinner model have been an opportunity to reconcile work and family obligations the Dutch welfare system in the 1990s and 2000s. Yet, this and relatively low child care usage (especially for longer hours/more days) are currently considered a strain to the welfare system in the anticipation of the gaps at the labor market due to the ageing of population.

3.6. Social Assistance

Replacing the former poor Law from 1854, the *Social assistance act* of 1965 (Algemene bijstandswet, ABW) provided the state-financed minimum income protection in the Netherlands (for an extensive overview of the social assistance reforms 1980 and 2006, see van Gerven, 2008). As a last resort safety-net it is also means-tested and intended as a complimentary and supplemented with other social security benefits (like WW, WAO, ZW). The originally rather complex system was reformed in 1986 and simplified in 1995 with setting different rates to single people, single parents and couples. The ABW of 1995 tightened both eligibility and entitlement rules. The young (under 21 later extended to 27) may only apply ABW in exceptional cases, and generally this group in need of financial support was transferred to the Youth Guarantee Programmes (JWG Act 1991). Since the revision ABW in 1995, considerable attention has been given activation. The receipt of the last resort social assistance has been conditional on claimants' willingness to work. Each claimant must register at the employment office, seek work, and be available for suitable work. Echoing the New Labour in the UK, the Dutch government introduced *the Act on Work and Assistance* (Wet Werk en Bijstand, WWB, Stb. 2003, 375) in 2004 with the intention to target the benefits to 'those who are not able to work (…), but the others are to be provided help in finding work'. The law

tightened the benefit rules to access and receipt and clearly aimed at replacing the passive income support with activating labor market participation assistance. The WWB also decentralized the social assistance benefit provision and reintegration services to the municipalities and allocated lump sums to the municipalities with a clear message to reduce the number of recipients. Everybody under the retirement age (with or without caring obligations) became obliged to seek work and following the law, suitable work was replaced with generally accepted work including nearly all work available in the Netherlands.

Many have argued that the 2007 *Social Support Act* (WMO), represented a tipping point, a step towards the realization of the Dutch participatory state (Delsen, 2016). In this model, the distribution of collective responsibilities is replaced by individual responsibilities. The aim of WMO is to empower citizens (whether they are young, old, disabled, jobless, migrants) to participate in society in full. Municipalities are tasked to help people with limitations by offering support in housing, employment, communication and transport. in the so-called kitchen table talks, the civil servants determine the needs of their clients and seek (in)formal solutions for appropriate care demands. The central element of WMO is to support people's own strengths (eigen kracht) and offer solutions for the community – as much as possible - though the community. The government and professional support are only the last frontier in care and social support.

The final kiss of goodbye is seen to be given during the coronation of the Dutch King Willem Alexander (17 September 2013) when the youngest monarch in Europe declared the end of the classic welfare state and the entry of the participation society 'where everyone who is able will be asked to take responsibility for their lives and immediate surroundings'(Delsen, 2016). This declaration followed the line of arguments by the Rutte I and II coalitions. On 1 January 2015 the *Participation Act* (Participatiewet) replaced the WWB, the *Sheltered Employment Act* (Wet Sociale Werkvoorziening, WSW) and a large part of the *Disability Benefit Act for the Young Handicapped* (Wet werk en Arbeidsondersteuning Jonggehandicapten, Wajong). About 700,000 people who can work but need support falls under the new Participation Act (Delsen 2016: 20). Municipalities are responsible for the support, but in first instance everybody is responsible for their own welfare. To advance these goals, the 2015 *Participation Act* for example extended the obligation for jobseekers to take up any available jobs (for instance a job with a daily commute up to three hours per day), rather than generally acceptable work (as was case in previous *Social Assistance Act)*.

Conclusion

In this chapter, we *seek to answer the question how the Dutch welfare system changed between 1994 and 2018?* The analyzed reforms form roughly three different sequences. Between 1994 and 2006, the Dutch social politics, driven by neoliberal visions, focused on cutting the costs and delimiting access to insurance schemes. Activation was the most dominant paradigm in this period, but due to lagging formalized welfare provision in area of care, some policy sectors of new social risks were still under expansion in this period. Between 2006 and 2010, we witness a reverse of this expansion. This second period is characterized by retrenchment, decentralization and refamiliarization of services. In this period, the participation ethos is becoming the master narrative of reform: the active citizenship mode is engaging both citizens, but also the local governments, non-governmental and market actors and steer them to participate in the empowerment of individuals and teaching individuals how to cope without the state (Titmuss 1974 in Delsen 2016: 12). In the last period from 2010 onwards, the activation paradigm became the new normal to all employment related protection, as the flexibilization was made the main virtue in labor market policies.

The analysis reveals a mixed picture on the types of changes. The conclusion points towards a combination of continuity with discontinuity and the changes that reflect the hegemony of participation, self-reliance and the urgency of the big society to step in. The picture that van Oorschot (2009) portrayed in the first volume of this Handbook is still valid: there is a (reinforced) shift from a model based on collective solidarity to a model based on individual responsibility. There is a continuity with respect to protection of universal rights of social protection, but the access has become more selective and conditional for insurance schemes. There is a shift from welfare to workfare around social assistance and (long-term) unemployment benefits. Decentralization has been the guiding principle for social services from the mid-2000s onwards, and care is deinstitutionalized back to the families. Marketisation of health care in the mid-2000s envisions the continental model closer to the liberal model with stronger link to competition, decentralization and individual risk-bearing. Solidarity has a strong connotation, but no longer as collective solidarity as in the past but as solidarity 2.0 organized at lowest level, between individuals and their communities. Under the context of participatory governance, under a new social contract people must step in, whereas the state is merely a regulator (and no longer the provider). This has been the main frontier of the social policy anno domini 2018 within the context of a participatory society.

On ideational level, these changes suggest a change that Peter Hall (1993) call as a paradigmatic change. The fundaments of welfare states have undergone a normative reorientation from a solidaristic and state-provided collective welfare state provision to a participatory state, where citizens actively engage in labor market and social service delivery and own the responsibility of their own wellbeing. In retrospective the incremental reforms and the introduction of the activation as the new normal have paved a way to the fundamental reorientation for the social assistance and unemployment insurance. The most abrupt changes

have been in the long-term care and WMO policies. Interestingly, the chapter provides proof for paradigmatic change even in the strong frozen insurance benefit landscape, that takes place over many decades and with small and often through mixed political reforms. Many of the workers' insurance systems are still well preserved, and seem to be rather resistant to change, as the institutionalist theories suggest. Is this an issue of institutional inertia or whether the momentum has not yet come to introduce more fundamental changes around pensions and unemployment insurance in the Netherlands, we do not know. But if Bonoli and Palier (2007) are right of the potential of small reforms paving a way to more structural reforms, we may very well witness this in the Netherlands in the coming decade(s). But the chapter also shows, that modern changes can also appear as reinventing the state, as the developments also points to the return to the values of Van Rhijn committee in the mid 1940s. Yet, there is no return to the past, each decade molds its own systems, and give rise to new welfare systems.

4. Outlook

In conclusion, the Netherlands still has a comprehensive social protection system, but its future is shadowed by concerns relating increasing inequality on the labor market and dualization of rights between protected and less well protected. The Dutch system still provides reasonably generous insurance benefits for labor market insiders with standard employment contracts (full time or part-time). The people in the margins of the labor market have, however, witnesses considerably less protection and much more insecurities. Furthermore, in context of a shrinking labor force in the future, the de-formalization of the care of the elderly accompanied by the de-formalization of child care may also lead to increasing inequalities at the labor market and to a triple bound: the working age population is expected to extend their working careers (and working hours) while at the same time they are expected to assume increasing responsibility for the care of both their children and their elderly parents (van Gerven 2016). In a short-term perspective, further cuts are expected for this sector and more responsibilities will probably be shifted towards the families and local governments. The extensive decentralization of social services being combined with cuts in social spending is likely to create regional inequalities in the future.

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